PROOF OF CLAIM ADDENDUM (POC Form 3)

EMPLOYEE NAME _____

Check only 1 box on this form. You must complete this form for each benefit requested.

❑Temporary Disability ❑Permanent Disability ❑Current Medical Care ❑Future Medical Care

❑Other _____

AMOUNT CLAIMED $

Describe the basis for the amount claimed for this benefit. You may attach supporting documents as appropriate. If you attach a supporting document, YOU MUST PLACE AN EXHIBIT NUMBER ON THE DOCUMENT AND IDENTIFY THE DOCUMENT WITH THE EXHIBIT NUMBER ON THIS FORM. (For example: "See attached EXHIBIT 2, Doctor's Report dated 02/02/02".)